PROPOSED AMENDMENT

SENATE AMENDMENTS TO H.B. 2209

(Reference to House engrossed bill)

Strike everything after the enacting clause and insert:

"Section 1. Title 20, chapter 4, article 3, Arizona Revised Statutes, is amended by adding section 20-826.05, to read:

20-826.05. Mental health coverage; parity; exception; definitions

A. A CORPORATION THAT ISSUES A GROUP HEALTH CARE PLAN THAT PROVIDES BOTH MEDICAL AND SURGICAL BENEFITS AND MENTAL HEALTH BENEFITS TO A GROUP SHALL NOT IMPOSE ANY TREATMENT LIMITATIONS OR FINANCIAL REQUIREMENTS WITH RESPECT TO THE MENTAL HEALTH BENEFIT COVERAGE UNLESS COMPARABLE TREATMENT LIMITATIONS OR FINANCIAL REQUIREMENTS ARE IMPOSED ON MEDICAL AND SURGICAL BENEFITS.

B. THE DIRECTOR SHALL ADOPT RULES TO CARRY OUT THIS SECTION.

C. THIS SECTION DOES NOT APPLY TO AUTISM SPECTRUM DISORDER.

D. FOR THE PURPOSES OF THIS SECTION:

1. "AUTISM SPECTRUM DISORDER" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-826.04.

2. "FINANCIAL REQUIREMENTS" INCLUDES:

(a) DEDUCTIBLES.

(b) COINSURANCE.

(c) COPAYMENTS.

(d) OTHER COST SHARING REQUIREMENTS.

(e) LIMITATIONS ON THE TOTAL AMOUNT THAT MAY BE PAID BY A PARTICIPANT OR BENEFICIARY WITH RESPECT TO BENEFITS UNDER THE PLAN OR COVERAGE.

(f) THE APPLICATION OF AN ANNUAL AND LIFETIME LIMIT.

3. "MEDICAL AND SURGICAL BENEFITS" MEANS BENEFITS WITH RESPECT TO MEDICAL OR SURGICAL SERVICES, AS DEFINED UNDER THE TERMS OF THE PLAN OR COVERAGE, BUT DOES NOT INCLUDE MENTAL HEALTH BENEFITS.

4. "MENTAL HEALTH BENEFITS" MEANS BENEFITS WITH RESPECT TO SERVICES, AS DEFINED UNDER THE TERMS AND CONDITIONS OF THE PLAN OR COVERAGE, FOR ALL CATEGORIES OF MENTAL HEALTH DISORDERS OR CONDITIONS THAT INVOLVE MENTAL

ILLNESS OR SUBSTANCE RELATED DISORDERS AND THAT FALL UNDER ANY OF THE DIAGNOSTIC CATEGORIES LISTED IN THE MENTAL DISORDERS SECTION OF THE INTERNATIONAL CLASSIFICATION OF DISEASE, IF THESE SERVICES ARE INCLUDED AS PART OF AN AUTHORIZED TREATMENT PLAN ACCORDING TO STANDARD PROTOCOLS AND MEET THE PLAN OR ISSUER'S MEDICAL NECESSITY CRITERIA.

5. "TREATMENT LIMITATIONS" MEANS LIMITATIONS ON THE FREQUENCY OF TREATMENT OR THE NUMBER OF VISITS OR DAYS OF COVERAGE OR OTHER SIMILAR LIMITS ON THE DURATION OR SCOPE OF TREATMENT UNDER THE PLAN OR COVERAGE.

Sec. 2. Section 20-841, Arizona Revised Statutes, is amended to read:

20-841. Prohibiting denial of certain contract benefits

A. Notwithstanding any provision of any subscription contract of a hospital and medical service corporation, benefits shall not be denied under the contract for any medical or surgical service performed by a holder of a license issued pursuant to title 32, chapter 7 or 11, if the service performed is within the lawful scope of ~~such~~ THE person's license, and if the service is surgical, ~~such~~ THE person is a member of the staff of an accredited hospital, and if ~~such~~ THE contract would have provided benefits if ~~such~~ THE service had been performed by a holder of a license issued pursuant to title 32, chapter 13.

B. If a subscription contract of a hospital and medical service corporation provides for or offers eye care services, the subscriber shall have freedom of choice to select either an optometrist or a physician and surgeon skilled in diseases of the eye to provide the examination, care~~,~~ or treatment for which the subscriber is eligible and ~~which~~ THAT falls within the scope of practice of the optometrist or physician and surgeon. Unless ~~such~~ A subscription contract otherwise provides, ~~there shall be no~~ reimbursement SHALL NOT BE MADE for ophthalmic materials, lenses, spectacles~~,~~ OR eyeglasses~~,~~ or appurtenances ~~thereto~~ TO OPHTHALMIC MATERIALS, LENSES, SPECTACLES OR EYEGLASSES.

C. SUBJECT TO SECTION 20-826.05, if any subscription contract of a hospital and medical service corporation is written to provide coverage for psychiatric, drug abuse or alcoholism services, reimbursement for ~~such~~ THOSE services shall be made in accordance with the terms of the contract without

regard to whether the covered services are rendered in a psychiatric special hospital or general hospital. Reimbursement for the cost of the service may be made directly to the person licensed or certified pursuant to title 32, chapter 13 or 19.1 or to the subscriber if the cost of the service has not been reimbursed to another provider or health care institution.

Sec. 3. Section 20-1057, Arizona Revised Statutes, is amended to read:

20-1057. Evidence of coverage by health care services organizations; renewability; definitions

A. Every enrollee in a health care plan shall be issued an evidence of coverage by the responsible health care services organization.

B. Any contract, except accidental death and dismemberment, applied for that provides family coverage shall also provide, as to such coverage of family members, that the benefits applicable for children shall be payable with respect to a newly born child of the enrollee from the instant of such child's birth, to a child adopted by the enrollee, regardless of the age at which the child was adopted, and to a child who has been placed for adoption with the enrollee and for whom the application and approval procedures for adoption pursuant to section 8-105 or 8-108 have been completed to the same extent that such coverage applies to other members of the family. The coverage for newly born or adopted children or children placed for adoption shall include coverage of injury or sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the contract may require that notification of birth, adoption or adoption placement of the child and payment of the required premium must be furnished to the insurer within thirty-one days after the date of birth, adoption or adoption placement in order to have the coverage continue beyond the thirty-one day period.

C. SUBJECT TO SECTION 20-1057.12, any contract, except accidental death and dismemberment, that provides coverage for psychiatric, drug abuse or alcoholism services shall require the health care services organization to provide reimbursement for such services in accordance with the terms of the

contract without regard to whether the covered services are rendered in a psychiatric special hospital or general hospital.

D. No evidence of coverage or amendment to the coverage shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage or amendment to the coverage has been filed with and approved by the director.

E. An evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate of contract, of:

1. The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan.

2. Any limitations of the services, kind of services, benefits or kind of benefits to be provided, including any deductible or copayment feature.

3. Where and in what manner information is available as to how services may be obtained.

4. The enrollee's obligation, if any, respecting charges for the health care plan.

F. An evidence of coverage shall not contain provisions or statements that are unjust, unfair, inequitable, misleading or deceptive, that encourage misrepresentation or that are untrue.

G. The director shall approve any form of evidence of coverage if the requirements of subsections E and F of this section are met. It is unlawful to issue such form until approved. If the director does not disapprove any such form within forty-five days after the filing of the form, it is deemed approved. If the director disapproves a form of evidence of coverage, the director shall notify the health care services organization. In the notice, the director shall specify the reasons for the director's disapproval. The director shall grant a hearing on such disapproval within fifteen days after a request for a hearing in writing is received from the health care services organization.

H. A health care services organization shall not cancel or refuse to renew an enrollee's evidence of coverage that was issued on a group basis without giving notice of the cancellation or nonrenewal to the enrollee and,

on request of the director, to the department of insurance. A notice by the organization to the enrollee of cancellation or nonrenewal of the enrollee's evidence of coverage shall be mailed to the enrollee at least sixty days before the effective date of such cancellation or nonrenewal. The notice shall include or be accompanied by a statement in writing of the reasons as stated in the contract for such action by the organization. Failure of the organization to comply with this subsection shall invalidate any cancellation or nonrenewal except a cancellation or nonrenewal for nonpayment of premium, for fraud or misrepresentation in the application or other enrollment documents or for loss of eligibility as defined in the evidence of coverage. A health care services organization shall not cancel an enrollee's evidence of coverage issued on a group basis because of the enrollee's or dependent's age, except for loss of eligibility as defined in the evidence of coverage, sex, health status-related factor, national origin or frequency of utilization of health care services of the enrollee. An evidence of coverage issued on a group basis shall clearly delineate all terms under which the health care services organization may cancel or refuse to renew an evidence of coverage for an enrollee or dependent. Nothing in this subsection prohibits the cancellation or nonrenewal of a health benefits plan contract issued on a group basis for any of the reasons allowed in section 20-2309. A health care services organization may cancel or nonrenew an evidence of coverage issued to an individual on a nongroup basis only for the reasons allowed by subsection N of this section.

I. A health care plan that provides coverage for surgical services for a mastectomy shall also provide coverage incidental to the patient's covered mastectomy for surgical services for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, treatment of physical complications for all stages of the mastectomy, including lymphedemas, and at least two external postoperative prostheses subject to all of the terms and conditions of the policy.

J. A contract that provides coverage for surgical services for a mastectomy shall also provide coverage for mammography screening performed on

dedicated equipment for diagnostic purposes on referral by a patient's physician, subject to all of the terms and conditions of the policy and according to the following guidelines:

1. A baseline mammogram for a woman from age thirty-five to thirty-nine.

2. A mammogram for a woman from age forty to forty-nine every two years or more frequently based on the recommendation of the woman's physician.

3. A mammogram every year for a woman fifty years of age and over.

K. Any contract that is issued to the enrollee and that provides coverage for maternity benefits shall also provide that the maternity benefits apply to the costs of the birth of any child legally adopted by the enrollee if all the following are true:

1. The child is adopted within one year of birth.

2. The enrollee is legally obligated to pay the costs of birth.

3. All preexisting conditions and other limitations have been met and all deductibles and copayments have been paid by the enrollee.

4. The enrollee has notified the insurer of the enrollee's acceptability to adopt children pursuant to section 8-105 within sixty days after such approval or within sixty days after a change in insurance policies, plans or companies.

L. The coverage prescribed by subsection K of this section is excess to any other coverage the natural mother may have for maternity benefits except coverage made available to persons pursuant to title 36, chapter 29 but not including coverage made available to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If such other coverage exists the agency, attorney or individual arranging the adoption shall make arrangements for the insurance to pay those costs that may be covered under that policy and shall advise the adopting parent in writing of the existence and extent of the coverage without disclosing any confidential information such as the identity of the natural parent. The enrollee adopting parents shall notify their health care services organization of the existence and extent of the other coverage. A health

care services organization is not required to pay any costs in excess of the amounts it would have been obligated to pay to its hospitals and providers if the natural mother and child had received the maternity and newborn care directly from or through that health care services organization.

M. Each health care services organization shall offer membership to the following in a conversion plan that provides the basic health care benefits required by the director:

1. Each enrollee including the enrollee's enrolled dependents leaving a group.

2. Each enrollee and the enrollee's dependents who would otherwise cease to be eligible for membership because of the age of the enrollee or the enrollee's dependents or the death or the dissolution of marriage of an enrollee.

N. A health care services organization shall not cancel or nonrenew an evidence of coverage issued to an individual on a nongroup basis, including a conversion plan, except for any of the following reasons and in compliance with the notice and disclosure requirements contained in subsection H of this section:

1. The individual has failed to pay premiums or contributions in accordance with the terms of the evidence of coverage or the health care services organization has not received premium payments in a timely manner.

2. The individual has performed an act or practice that constitutes fraud or the individual made an intentional misrepresentation of material fact under the terms of the evidence of coverage.

3. The health care services organization has ceased to offer coverage to individuals that is consistent with the requirements of sections 20-1379 and 20-1380.

4. If the health care services organization offers a health care plan in this state through a network plan, the individual no longer resides, lives or works in the service area served by the network plan or in an area for which the health care services organization is authorized to transact business but only if the coverage is terminated uniformly without regard to any health status-related factor of the covered individual.

5. If the health care services organization offers health coverage in this state in the individual market only through one or more bona fide associations, the membership of the individual in the association has ceased but only if that coverage is terminated uniformly without regard to any health status-related factor of any covered individual.

O. A conversion plan may be modified if the modification complies with the notice and disclosure provisions for cancellation and nonrenewal under subsection H of this section. A modification of a conversion plan that has already been issued shall not result in the effective elimination of any benefit originally included in the conversion plan.

P. Any person who is a United States armed forces reservist, who is ordered to active military duty on or after August 22, 1990 and who was enrolled in a health care plan shall have the right to reinstate such coverage upon release from active military duty subject to the following conditions:

1. The reservist shall make written application to the health plan within ninety days of discharge from active military duty or within one year of hospitalization continuing after discharge. Coverage shall be effective upon receipt of the application by the health plan.

2. The health plan may exclude from such coverage any health or physical condition arising during and occurring as a direct result of active military duty.

Q. The director shall adopt emergency rules THAT ARE applicable to persons who are leaving active service in the armed forces of the United States and returning to civilian status consistent with subsection P of this section ~~including~~ AND THAT INCLUDE:

1. Conditions of eligibility.

2. Coverage of dependents.

3. Preexisting conditions.

4. Termination of insurance.

5. Probationary periods.

6. Limitations.

7. Exceptions.

8. Reductions.

9. Elimination periods.

10. Requirements for replacement.

11. Any other conditions of evidences of coverage.

R. Any contract that provides maternity benefits shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight hours following a normal vaginal delivery or ninety-six hours following a cesarean section. The contract shall not require the provider to obtain authorization from the health care services organization for prescribing the minimum length of stay required by this subsection. The contract may provide that an attending provider in consultation with the mother may discharge the mother or the newborn child before the expiration of the minimum length of stay required by this subsection. The health care services organization shall not:

1. Deny the mother or the newborn child eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract solely for the purpose of avoiding the requirements of this subsection.

2. Provide monetary payments or rebates to mothers to encourage those mothers to accept less than the minimum protections available pursuant to this subsection.

3. Penalize or otherwise reduce or limit the reimbursement of an attending provider because that provider provided care to any insured under the contract in accordance with this subsection.

4. Provide monetary or other incentives to an attending provider to induce that provider to provide care to an insured under the contract in a manner that is inconsistent with this subsection.

5. Except as described in subsection S of this section, restrict benefits for any portion of a period within the minimum length of stay in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

S. Nothing in subsection R of this section:

1. Requires a mother to give birth in a hospital or to stay in the hospital for a fixed period of time following the birth of the child.

2. Prevents a health care services organization from imposing deductibles, coinsurance or other cost sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn child under the contract, except that any coinsurance or other cost sharing for any portion of a period within a hospital length of stay required pursuant to subsection R of this section shall not be greater than the coinsurance or cost sharing for any preceding portion of that stay.

3. Prevents a health care services organization from negotiating the level and type of reimbursement with a provider for care provided in accordance with subsection R of this section.

T. Any contract or evidence of coverage that provides coverage for diabetes shall also provide coverage for equipment and supplies that are medically necessary and that are prescribed by a health care provider including:

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

3. Test strips for glucose monitors and visual reading and urine testing strips.

4. Insulin preparations and glucagon.

5. Insulin cartridges.

6. Drawing up devices and monitors for the visually impaired.

7. Injection aids.

8. Insulin cartridges for the legally blind.

9. Syringes and lancets including automatic lancing devices.

10. Prescribed oral agents for controlling blood sugar that are included on the plan formulary.

11. To the extent coverage is required under medicare, podiatric appliances for prevention of complications associated with diabetes.

12. Any other device, medication, equipment or supply for which coverage is required under medicare from and after January 1, 1999. The coverage required in this paragraph is effective six months after the coverage is required under medicare.

U. Nothing in subsection T of this section:

1. Entitles a member or enrollee of a health care services organization to equipment or supplies for the treatment of diabetes that are not medically necessary as determined by the health care services organization medical director or the medical director's designee.

2. Provides coverage for diabetic supplies obtained by a member or enrollee of a health care services organization without a prescription unless otherwise permitted pursuant to the terms of the health care plan.

3. Prohibits a health care services organization from imposing deductibles, coinsurance or other cost sharing in relation to benefits for equipment or supplies for the treatment of diabetes.

V. Any contract or evidence of coverage that provides coverage for prescription drugs shall not limit or exclude coverage for any prescription drug prescribed for the treatment of cancer on the basis that the prescription drug has not been approved by the United States food and drug administration for the treatment of the specific type of cancer for which the prescription drug has been prescribed, if the prescription drug has been recognized as safe and effective for treatment of that specific type of cancer in one or more of the standard medical reference compendia prescribed in subsection W of this section or medical literature that meets the criteria prescribed in subsection W of this section. The coverage required under this subsection includes covered medically necessary services associated with the administration of the prescription drug. This subsection does not:

1. Require coverage of any prescription drug used in the treatment of a type of cancer if the United States food and drug administration has determined that the prescription drug is contraindicated for that type of cancer.

2. Require coverage for any experimental prescription drug that is not approved for any indication by the United States food and drug administration.

3. Alter any law with regard to provisions that limit the coverage of prescription drugs that have not been approved by the United States food and drug administration.

4. Notwithstanding section 20-1057.02, require reimbursement or coverage for any prescription drug that is not included in the drug formulary or list of covered prescription drugs specified in the contract or evidence of coverage.

5. Notwithstanding section 20-1057.02, prohibit a contract or evidence of coverage from limiting or excluding coverage of a prescription drug, if the decision to limit or exclude coverage of the prescription drug is not based primarily on the coverage of prescription drugs required by this section.

6. Prohibit the use of deductibles, coinsurance, copayments or other cost sharing in relation to drug benefits and related medical benefits offered.

W. For the purposes of subsection V of this section:

1. The acceptable standard medical reference compendia are the following:

(a) The American medical association drug evaluations, a publication of the American medical association.

(b) The American hospital formulary service drug information, a publication of the American society of health system pharmacists.

(c) Drug information for the health care provider, a publication of the United States pharmacopoeia convention.

2. Medical literature may be accepted if all of the following apply:

(a) At least two articles from major peer reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.

(b) No article from a major peer reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.

(c) The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee

of medical journal editors or is published in a journal specified by the United States department of health and human services as acceptable peer reviewed medical literature pursuant to section 186(t)(2)(B) of the social security act (42 United States Code section 1395x(t)(2)(B)).

X. A health care services organization shall not issue or deliver any advertising matter or sales material to any person in this state until the health care services organization files the advertising matter or sales material with the director. This subsection does not require a health care services organization to have the prior approval of the director to issue or deliver the advertising matter or sales material. If the director finds that the advertising matter or sales material, in whole or in part, is false, deceptive or misleading, the director may issue an order disapproving the advertising matter or sales material, directing the health care services organization to cease and desist from issuing, circulating, displaying or using the advertising matter or sales material within a period of time specified by the director but not less than ten days and imposing any penalties prescribed in this title. At least five days before issuing an order pursuant to this subsection, the director shall provide the health care services organization with a written notice of the basis of the order to provide the health care services organization with an opportunity to cure the alleged deficiency in the advertising matter or sales material within a single five day period for the particular advertising matter or sales material at issue. The health care services organization may appeal the director's order pursuant to title 41, chapter 6, article 10. Except as otherwise provided in this subsection, a health care services organization may obtain a stay of the effectiveness of the order as prescribed in section 20-162. If the director certifies in the order and provides a detailed explanation of the reasons in support of the certification that continued use of the advertising matter or sales material poses a threat to the health, safety or welfare of the public, the order may be entered immediately without opportunity for cure and the effectiveness of the order is not stayed pending the hearing on the notice of appeal but the hearing shall be promptly instituted and determined.

Y. Any contract or evidence of coverage that is offered by a health care services organization and that contains a prescription drug benefit shall provide coverage of medical foods to treat inherited metabolic disorders as provided by this section.

Z. The metabolic disorders triggering medical foods coverage under this section shall:

1. Be part of the newborn screening program prescribed in section 36-694.

2. Involve amino acid, carbohydrate or fat metabolism.

3. Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues.

4. Require specially processed or treated medical foods that are generally available only under the supervision and direction of a physician who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse practitioner who is licensed pursuant to title 32, chapter 15, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

AA. Medical foods eligible for coverage under this section shall be prescribed or ordered under the supervision of a physician licensed pursuant to title 32, chapter 13 or 17 or a registered nurse practitioner who is licensed pursuant to title 32, chapter 15 as medically necessary for the therapeutic treatment of an inherited metabolic disease.

BB. A health care services organization shall cover at least fifty per cent of the cost of medical foods prescribed to treat inherited metabolic disorders and covered pursuant to this section. An organization may limit the maximum annual benefit for medical foods under this section to five thousand dollars, which applies to the cost of all prescribed modified low protein foods and metabolic formula.

CC. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

DD. For the purposes of:

1. This section:

(a) "Inherited metabolic disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program prescribed in section 36-694.

(b) "Medical foods" means modified low protein foods and metabolic formula.

(c) "Metabolic formula" means foods that are all of the following:

(i) Formulated to be consumed or administered enterally under the supervision of a physician who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse practitioner who is licensed pursuant to title 32, chapter 15.

(ii) Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs.

(iii) Administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation.

(iv) Essential to a person's optimal growth, health and metabolic homeostasis.

(d) "Modified low protein foods" means foods that are all of the following:

(i) Formulated to be consumed or administered enterally under the supervision of a physician who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse practitioner who is licensed pursuant to title 32, chapter 15.

(ii) Processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein.

(iii) Administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation.

(iv) Essential to a person's optimal growth, health and metabolic homeostasis.

2. Subsection B of this section, "child", for purposes of initial coverage of an adopted child or a child placed for adoption but not for purposes of termination of coverage of such child, means a person under ~~the age of~~ eighteen years OF AGE.

Sec. 4. Title 20, chapter 4, article 9, Arizona Revised Statutes, is amended by adding section 20-1057.12, to read:

20-1057.12. Mental health coverage; parity; exception; definitions

A. A HEALTH CARE SERVICES ORGANIZATION THAT ISSUES A GROUP HEALTH CARE PLAN THAT PROVIDES BOTH MEDICAL AND SURGICAL BENEFITS AND MENTAL HEALTH BENEFITS TO A GROUP SHALL NOT IMPOSE ANY TREATMENT LIMITATIONS OR FINANCIAL REQUIREMENTS WITH RESPECT TO THE MENTAL HEALTH BENEFIT COVERAGE UNLESS COMPARABLE TREATMENT LIMITATIONS OR FINANCIAL REQUIREMENTS ARE IMPOSED ON MEDICAL AND SURGICAL BENEFITS.

B. THE DIRECTOR SHALL ADOPT RULES TO CARRY OUT THIS SECTION.

C. THIS SECTION DOES NOT APPLY TO AUTISM SPECTRUM DISORDER.

D. FOR THE PURPOSES OF THIS SECTION:

1. "AUTISM SPECTRUM DISORDER" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-1057.11.

2. "FINANCIAL REQUIREMENTS" INCLUDES:

(a) DEDUCTIBLES.

(b) COINSURANCE.

(c) COPAYMENTS.

(d) OTHER COST SHARING REQUIREMENTS.

(e) LIMITATIONS ON THE TOTAL AMOUNT THAT MAY BE PAID BY A PARTICIPANT OR BENEFICIARY WITH RESPECT TO BENEFITS UNDER THE PLAN OR COVERAGE.

(f) THE APPLICATION OF AN ANNUAL AND LIFETIME LIMIT.

3. "MEDICAL AND SURGICAL BENEFITS" MEANS BENEFITS WITH RESPECT TO MEDICAL OR SURGICAL SERVICES, AS DEFINED UNDER THE TERMS OF THE PLAN OR COVERAGE, BUT DOES NOT INCLUDE MENTAL HEALTH BENEFITS.

4. "MENTAL HEALTH BENEFITS" MEANS BENEFITS WITH RESPECT TO SERVICES, AS DEFINED UNDER THE TERMS AND CONDITIONS OF THE PLAN OR COVERAGE, FOR ALL CATEGORIES OF MENTAL HEALTH DISORDERS OR CONDITIONS THAT INVOLVE MENTAL ILLNESS OR SUBSTANCE RELATED DISORDERS THAT FALL UNDER ANY OF THE DIAGNOSTIC CATEGORIES LISTED IN THE MENTAL DISORDERS SECTION OF THE INTERNATIONAL CLASSIFICATION OF DISEASE, IF THESE SERVICES ARE INCLUDED AS PART OF AN AUTHORIZED TREATMENT PLAN ACCORDING TO STANDARD PROTOCOLS AND MEET THE PLAN OR ISSUER'S MEDICAL NECESSITY CRITERIA.

5. "TREATMENT LIMITATIONS" MEANS LIMITATIONS ON THE FREQUENCY OF TREATMENT OR THE NUMBER OF VISITS OR DAYS OF COVERAGE OR OTHER SIMILAR LIMITS ON THE DURATION OR SCOPE OF TREATMENT UNDER THE PLAN OR COVERAGE.

Sec. 5. Title 20, chapter 6, article 5, Arizona Revised Statutes, is amended by adding sections 20-1402.04 and 20-1404.04, to read:

20-1402.04. Mental health coverage; parity; exception; definitions

A. A GROUP DISABILITY INSURER THAT ISSUES A GROUP HEALTH CARE PLAN THAT PROVIDES BOTH MEDICAL AND SURGICAL BENEFITS AND MENTAL HEALTH BENEFITS TO A GROUP SHALL NOT IMPOSE ANY TREATMENT LIMITATIONS OR FINANCIAL REQUIREMENTS WITH RESPECT TO THE MENTAL HEALTH BENEFIT COVERAGE UNLESS COMPARABLE TREATMENT LIMITATIONS OR FINANCIAL REQUIREMENTS ARE IMPOSED ON MEDICAL AND SURGICAL BENEFITS.

B. THE DIRECTOR SHALL ADOPT RULES TO CARRY OUT THIS SECTION.

C. THIS SECTION DOES NOT APPLY TO AUTISM SPECTRUM DISORDER.

D. FOR THE PURPOSES OF THIS SECTION:

1. "AUTISM SPECTRUM DISORDER" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-1402.03.

2. "FINANCIAL REQUIREMENTS" INCLUDES:

(a) DEDUCTIBLES.

(b) COINSURANCE.

(c) COPAYMENTS.

(d) OTHER COST SHARING REQUIREMENTS.

(e) LIMITATIONS ON THE TOTAL AMOUNT THAT MAY BE PAID BY A PARTICIPANT OR BENEFICIARY WITH RESPECT TO BENEFITS UNDER THE PLAN OR COVERAGE.

(f) THE APPLICATION OF AN ANNUAL AND LIFETIME LIMIT.

3. "MEDICAL AND SURGICAL BENEFITS" MEANS BENEFITS WITH RESPECT TO MEDICAL OR SURGICAL SERVICES, AS DEFINED UNDER THE TERMS OF THE PLAN OR COVERAGE, BUT DOES NOT INCLUDE MENTAL HEALTH BENEFITS.

4. "MENTAL HEALTH BENEFITS" MEANS BENEFITS WITH RESPECT TO SERVICES, AS DEFINED UNDER THE TERMS AND CONDITIONS OF THE PLAN OR COVERAGE, FOR ALL CATEGORIES OF MENTAL HEALTH DISORDERS OR CONDITIONS THAT INVOLVE MENTAL ILLNESS OR SUBSTANCE RELATED DISORDERS AND THAT FALL UNDER ANY OF THE DIAGNOSTIC CATEGORIES LISTED IN THE MENTAL DISORDERS SECTION OF THE INTERNATIONAL CLASSIFICATION OF DISEASE, IF THESE SERVICES ARE INCLUDED AS PART OF AN AUTHORIZED TREATMENT PLAN ACCORDING TO STANDARD PROTOCOLS AND MEET THE PLAN OR ISSUER'S MEDICAL NECESSITY CRITERIA.

5. "TREATMENT LIMITATIONS" MEANS LIMITATIONS ON THE FREQUENCY OF TREATMENT OR THE NUMBER OF VISITS OR DAYS OF COVERAGE OR OTHER SIMILAR LIMITS ON THE DURATION OR SCOPE OF TREATMENT UNDER THE PLAN OR COVERAGE.

20-1404.04. Mental health coverage; parity; exception; definitions

A. A BLANKET DISABILITY INSURER THAT ISSUES A GROUP HEALTH CARE PLAN THAT PROVIDES BOTH MEDICAL AND SURGICAL BENEFITS AND MENTAL HEALTH BENEFITS TO A GROUP SHALL NOT IMPOSE ANY TREATMENT LIMITATIONS OR FINANCIAL REQUIREMENTS WITH RESPECT TO THE MENTAL HEALTH BENEFIT COVERAGE UNLESS COMPARABLE TREATMENT LIMITATIONS OR FINANCIAL REQUIREMENTS ARE IMPOSED ON MEDICAL AND SURGICAL BENEFITS.

B. THE DIRECTOR SHALL ADOPT RULES TO CARRY OUT THIS SECTION.

C. THIS SECTION DOES NOT APPLY TO AUTISM SPECTRUM DISORDER.

D. FOR THE PURPOSES OF THIS SECTION:

1. "AUTISM SPECTRUM DISORDER" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-1404.03.

2. "FINANCIAL REQUIREMENTS" INCLUDES:

(a) DEDUCTIBLES.

(b) COINSURANCE.

(c) COPAYMENTS.

(d) OTHER COST SHARING REQUIREMENTS.

(e) LIMITATIONS ON THE TOTAL AMOUNT THAT MAY BE PAID BY A PARTICIPANT OR BENEFICIARY WITH RESPECT TO BENEFITS UNDER THE PLAN OR HEALTH INSURANCE COVERAGE.

(f) THE APPLICATION OF AN ANNUAL AND LIFETIME LIMIT.

3. "MEDICAL AND SURGICAL BENEFITS" MEANS BENEFITS WITH RESPECT TO MEDICAL OR SURGICAL SERVICES, AS DEFINED UNDER THE TERMS OF THE PLAN OR COVERAGE, BUT DOES NOT INCLUDE MENTAL HEALTH BENEFITS.

4. "MENTAL HEALTH BENEFITS" MEANS BENEFITS WITH RESPECT TO SERVICES, AS DEFINED UNDER THE TERMS AND CONDITIONS OF THE PLAN OR COVERAGE FOR ALL CATEGORIES OF MENTAL HEALTH DISORDERS OR CONDITIONS THAT INVOLVE MENTAL ILLNESS OR SUBSTANCE RELATED DISORDERS AND THAT FALL UNDER ANY OF THE DIAGNOSTIC CATEGORIES LISTED IN THE MENTAL DISORDERS SECTION OF THE INTERNATIONAL CLASSIFICATION OF DISEASE, IF THESE SERVICES ARE INCLUDED AS PART OF AN AUTHORIZED TREATMENT PLAN ACCORDING TO STANDARD PROTOCOLS AND MEET THE PLAN OR ISSUER'S MEDICAL NECESSITY CRITERIA.

5. "TREATMENT LIMITATIONS" MEANS LIMITATIONS ON THE FREQUENCY OF TREATMENT OR THE NUMBER OF VISITS OR DAYS OF COVERAGE OR OTHER SIMILAR LIMITS ON THE DURATION OR SCOPE OF TREATMENT UNDER THE PLAN OR COVERAGE.

Sec. 6. Section 20-1406, Arizona Revised Statutes, is amended to read:

20-1406. Prohibiting denial of certain contract benefits

A. Notwithstanding any provision of any group disability insurance contract or blanket disability insurance contract, benefits shall not be denied under the contract for any medical or surgical service performed by a holder of a license issued pursuant to title 32, chapter 7 or 11 or BY a registered nurse practitioner who is licensed pursuant to title 32, chapter 15, if the service performed is within the lawful scope of ~~such~~ THE person's license, and if the service is surgical, ~~such~~ THE person is a member of the staff of an accredited hospital, and if ~~such~~ THE contract would have provided benefits if ~~such~~ THE service had been performed by a holder of a license issued pursuant to title 32, chapter 13.

B. If any group disability insurance contract or blanket disability insurance contract provides for or offers eye care services, the subscriber shall have freedom of choice to select either an optometrist or a physician

and surgeon skilled in diseases of the eye to provide the examination, care, or treatment for which the subscriber is eligible and ~~which~~ THAT falls within the scope of practice of the optometrist or physician and surgeon. Unless ~~such~~ A group disability insurance contract or blanket disability insurance contract otherwise provides, ~~there shall be no~~ reimbursement SHALL NOT BE MADE for ophthalmic materials, lenses, spectacles~~,~~ OR eyeglasses~~,~~ or appurtenances ~~thereto~~ TO OPHTHALMIC MATERIALS LENSES, SPECTACLES OR EYEGLASSES.

C. SUBJECT TO SECTIONS 20-1402.04 AND 20-1404.04, if any group disability insurance contract is written to provide coverage for psychiatric, drug abuse or alcoholism services, reimbursement for ~~such~~ THOSE services shall be made in accordance with the terms of the contract without regard to whether the covered services are rendered in a psychiatric special hospital or general hospital. Reimbursement for the cost of the service may be made directly to the person licensed or certified pursuant to title 32, chapter 13 or 19.1 or to the subscriber if the cost of the service has not been reimbursed to another provider or health care institution.

Sec. 7. Applicability

This act applies to policies, contracts and plans that are issued or renewed on or after January 1, 2009."

Amend title to conform

TOM O'HALLERAN

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